STATE OF MONTANA - DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

FOR USE BY NURSING FACILITIES — PLEASE TYPE OR PRINT — FORM NO. MA-3

NURSING FACILITY - NAME AND ADDRESS	PROV. NO.	MAIL TO **MONTANA MEDICAID** DEPT. MA-3 PO.O BOX 8000 HELENA, MT 59604 TELEPHONE NUMBER 1-800-624-3958	

PATIENT: LAST NAME **FIRST** **MIDDLE INITIAL** — M S E X F — COUNTY — INDIVIDUAL NUMBER — AUTH.

1

DIAGNOSIS	DIAG. CODE	DATE OF BIRTH (MO. DAY YEAR)	DATE ADMITTED (MO. DAY YEAR)	STATEMENT PERIOD FROM (MO DAY YEAR)	STATEMENT PERIOD TO (MO. DAY YEAR)	
NEW DIAGNOSIS/RECENT COMPLICATIONS	DIAG. CODE	NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(LESS) PERSONAL RESOURCES →	NET CHARGES

PATIENT: LAST NAME **FIRST** **MIDDLE INITIAL** — M S E X F — COUNTY — INDIVIDUAL NUMBER — AUTH.

2

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4

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5

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NEW DIAGNOSIS/RECENT COMPLICATIONS	DIAG. CODE	NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(LESS) PERSONAL RESOURCES →	NET CHARGES

PATIENT: LAST NAME **FIRST** **MIDDLE INITIAL** — M S E X F — COUNTY — INDIVIDUAL NUMBER — AUTH.

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DIAGNOSIS	DIAG. CODE	DATE OF BIRTH (MO. DAY YEAR)	DATE ADMITTED (MO. DAY YEAR)	STATEMENT PERIOD FROM (MO DAY YEAR)	STATEMENT PERIOD TO (MO. DAY YEAR)	
NEW DIAGNOSIS/RECENT COMPLICATIONS	DIAG. CODE	NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(LESS) PERSONAL RESOURCES →	NET CHARGES

I hereby certify that the care, services and supplies itemized have been furnished, the amounts listed are due and, except as noted, no part thereof has been paid; payment of fees made in accordance with established schedules is accepted as payment in full. I further certify that the service(s) indicated above has/have been provided without regard to race, color, national origin, creed, sex, religion, political ideas, marital status, age or handicap. I hereby agree to maintain and furnish on request to the Department, the Montana Medicaid Fraud Control Bureau, the U.S. DHHS, the Comptroller General of the U.S., or any of their duly authorized agents or representatives such records as necessary to disclose fully the extent of care, services, and supplies provided to individuals under the Montana Medical Assistance Program.
I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS. I hereby agree to comply with all rules and requirements pertaining to the Montana Medicaid Program, including but not limited to, Title XIX of the Social Security Act, Montana Statutes and the Administrative Rules of Montana.

TOTAL CHARGES THIS SHEET	
TOTAL CHARGES THIS MONTH	

PROVIDER'S SIGNATURE _____ DATE _____